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May 8, 2020

Seema Verma, MPH  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: File code CMS-1733-P**

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "Medicare Program; FY 2021 Hospice Wage Index and Payment Rate Update" in the *Federal Register*, vol. 85 no. 73, p. 20949 (April 15, 2020). We appreciate CMS's ongoing efforts to administer and improve the payment system for hospice services, particularly given the many competing demands on the agency's staff.

The Commission's comments are organized into three sections: the update for fiscal year (FY) 2021, the proposal to sunset the service intensity adjustment budget neutrality factor, and the revisions to the statistical area delineations used to construct the wage indexes.

**Proposed update to the FY 2021 payment rates and aggregate cap**

CMS has proposed a payment update of 2.6 percent to the FY 2021 hospice payment rates and hospice aggregate cap amount, as required by statute.

*Comment*

We recognize that CMS is required by statute to propose an increase to the FY 2021 base rates and aggregate cap of 2.6 percent. However, in our March 2020 report to the Congress, the Commission recommended that the Congress eliminate the payment update for FY 2021 (i.e., hold the payment rates for FY 2021 at the FY 2020 levels) and wage adjust and reduce the hospice aggregate cap by 20 percent.<sup>1</sup>

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<sup>1</sup> Medicare Payment Advisory Commission. 2020. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

In the March 2020 report, the Commission found that indicators of access to care were positive and the aggregate Medicare margin was strong. The number of hospice providers, number of beneficiaries enrolled in hospice, days of hospice care, and average length of stay increased in 2018. The rate of marginal profit was 16 percent in 2017. As the number of for-profit providers increased by 4 percent in 2019, access to capital appears strong. The aggregate Medicare margin in 2017 reached 12.6 percent—a 1.7 percentage point increase from the prior year. The projected 2020 margin is 12.6 percent.

Given the aggregate Medicare margin in the industry and the other positive payment adequacy indicators, the Commission concluded that the aggregate level of payments could be reduced and would still be sufficient to cover hospice providers' costs and preserve beneficiaries' access to care. In light of substantial variation in financial performance across providers, we developed a two-part recommendation to focus payment reductions on providers with the highest margins. The Commission recommended that the payment rates be unchanged in FY 2021 at the 2020 levels for all providers, and the hospice aggregate cap be reduced by 20 percent as a way to focus payment reductions on providers with disproportionately long stays and high margins. The recommendation would also wage adjust the hospice aggregate cap to make it more equitable across providers. Overall, this recommendation would bring aggregate payments closer to costs, would lead to savings for the Medicare program and taxpayers, and would be consistent with the Commission's principle that it is incumbent on Medicare to maintain financial pressure on providers to constrain costs.

### **Proposal to sunset the service intensity adjustment budget neutrality factor**

In 2016, CMS revised the structure of payments for hospice routine home care (RHC). These changes were directionally consistent with the Commission's 2009 recommendation to reform the hospice payment system. Effective 2016, CMS moved away from a single per diem payment rate for RHC to two per diem payment rates: a higher rate for days 1–60 and a lower rate for days 61 and beyond. In addition, CMS established service intensity adjustment (SIA) payments, as a way to increase payments for certain visits that occur in the last days of life. SIA payments are additional payments (compensated at an hourly rate) for registered nurse and social worker visits that occur during the last seven days of life for patients receiving RHC. To maintain budget neutrality of SIA payments in 2016, CMS estimated the expected amount of SIA payments for 2016 using 2014 claims data. CMS then reduced the 2016 RHC base rates for days 1–60 and days 61 and beyond by two SIA payment budget neutrality factors (SBNFs) to account for the expected amount of SIA payments that would occur during those periods of the hospice episode. Each year since 2016, CMS has revised the SBNFs using the most recent complete claims data available to help ensure SIA payments remain budget neutral going forward.

In this rule, CMS is proposing to sunset the SBNFs beginning FY 2021. CMS stated that the magnitude of the SBNFs have been minor and proposed to discontinue the SBNFs to simplify rate setting. In the proposed rule, CMS provided the SBNF adjustments over time (Table 1).

**Table 1. Service intensity adjustment budget neutrality factors, 2016–2020**

|         | Days 1–60 | Days 61+ |
|---------|-----------|----------|
| FY 2016 | 0.9806    | 0.9957   |
| FY 2017 | 1.0000    | 0.9999   |
| FY 2018 | 1.0017    | 1.0005   |
| FY 2019 | 0.9991    | 0.9998   |
| FY 2020 | 0.9924    | 0.9982   |

Note: FY (fiscal year).

Source: FY 2021 hospice proposed rule.

### *Comment*

The Commission does not support CMS’s proposal to sunset the SBNFs and believes the SBNF recalibration should continue on an annual basis. Consistent with our comments on the FY 2016 hospice proposed rule, we continue to believe that the SBNFs serve an important purpose, which is to retain budget neutrality going forward if visits in the last seven days of life increase. As we have noted over the years, data suggest that some hospice beneficiaries are not receiving visits in the last days of life, and it may be appropriate that visits in the last days of life increase. Although the provision of visits in the last seven days of life was relatively stable between 2015 and 2018, there is uncertainty about future trends. In August 2019, CMS added to Hospice Compare a measure of the percentage of patients who received at least one visit during the last three days of life from a registered nurse or other clinician. The visibility of the Hospice Compare data may lead to changes in practice patterns. In addition, beginning FY 2020, CMS increased the SIA payment rate for visits in the last seven days of life by 40 percent. It remains to be seen whether the increased payment rate will spur additional provision of visits at the end of life. If visits in the last days of life increase, the SBNFs will help ensure that the increased payments are budget neutral by reducing the two RHC per diem rates to compensate. Given that the two RHC per diem payment rates are substantially above hospice providers’ estimated costs, we believe it is especially important that CMS retain its ability to ensure that the SIA payments do not lead to further widening of the gap between RHC payments and costs.

If CMS wishes to simplify rate setting, an alternative approach CMS could consider is to shift from the use of two SBNFs for days 1–60 and days 61+ to a single SBNF applied to both RHC per diem rates. In addition to reducing the number of adjustments calculated each year, this approach would have the benefit of modestly increasing payments for days 1–60 and reducing payments for days 61 and beyond. Given that long hospice stays are currently more profitable than short stays, an increase in the payment rate for days 1–60 and a decrease in the payment rate for days 61 and beyond would be a step toward improving payment accuracy.

## **Adoption of the Office of Management and Budget's (OMB's) geographic area delineations to establish the wage indexes**

The payment rates for each hospice are adjusted to reflect the relative differences in area wage levels using geographic areas (called core-based statistical areas, or CBSAs) delineated by the Office of Management and Budget. Periodically, OMB revises the delineations and CMS adopts them in establishing the wage index values. On September 14, 2018, OMB published an updated set of delineations that included the creation of new CBSAs, the splitting of some existing CBSAs, and changes in the designation of some areas from rural to urban and from urban to rural. In previous adoptions of OMB's revised delineations, CMS has included a one-year transition that blended old and new wage index values to avoid large changes to the wage index values.

Consistent with prior actions, this year CMS proposes to adopt the most recent delineations of geographic areas and include a one-year transition. This year, however, CMS proposes to take a different approach to the one-year transition. CMS proposes to limit the reduction to any wage index value to 5 percent in one year, thus mitigating the impact on hospices whose wage index values will decrease. CMS proposes to allow hospices whose relative index values would increase to receive the full benefit of the increased wage index value. The adoption of the new wage index values would be done in a budget-neutral manner.

### *Comment*

The Commission supports the adoption of the new delineations of the geographic areas and the use of a one-year transition to ease the impacts of changes to the wage index values. Regarding the limit on decreases to the wage index values, the Commission supports eliminating wage index changes of more than 5 percent in one year. However, the Commission believes the limit should apply to both increases and decreases in the wage index, not just to decreases. This way, no provider would have its wage index value increase or decrease by more than 5 percent for FY 2021. Consistent with CMS's proposed approach, the implementation of the revised relative wage index values (where changes are limited to plus or minus 5 percent) should be done in a budget-neutral manner.

The Commission also reiterates its recommendations on wage index reform included in the Commission's 2007 report to the Congress.<sup>2</sup> We recommended that the Congress repeal the existing hospital wage index and instead implement a market-level wage index for use across other prospective payment systems, including certain post-acute care providers. Specifically, our recommended wage index system would:

- use wage data from all employers and industry-specific occupational weights,
- adjust for geographic differences in the ratio of benefits to wages,

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<sup>2</sup> Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare*. Washington, DC: MedPAC.

- adjust at the county level and smooth large differences between counties, and
- include a transition period to mitigate large changes in wage index values.

The wage index system we proposed would more fully reflect input prices, automatically adjust for occupational mix, reduce circularity, and reduce large differences between adjoining areas compared with the current system. Two research evaluations commissioned by the Secretary concluded that MedPAC's proposed wage index system would be an improvement over Medicare's current hospital wage index system.<sup>3</sup> We understand that eliminating the current wage index system, and the associated apparatus (such as the rural floors and reclassifications), would require Congressional action, but we urge the agency to consider our recommendations and make adjustments to the current system where it has the discretionary authority to do so.

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact James E. Mathews, MedPAC's Executive Director, at (202) 220-3700.

Sincerely,



Francis J. Crosson, M.D.  
Chairman

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<sup>3</sup> Institute of Medicine. 2011. *Geographic adjustment in Medicare payment, Phase I: Improving accuracy. Second edition*. Washington, DC: The National Academies Press.

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<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/CMS1237065.html>